THE AFFORDABLE CARE ACT

California Mental Health Planning Council
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The Affordable Care Act Overview

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San Bernardino County Efforts

Multiple departments within the County of San Bernardino have been collaborating for more than two years to evaluate the opportunities, risks and financial impacts of the Patient Protection and Affordable Care Act (ACA).

Overview of San Bernardino County

- 400,000* is the estimated number of uninsured residents with annual incomes in the 0-400% Federal Poverty Level (FPL) range.
  - 229,000 residents between 0-138% FPL (income $0-$15,864)
  - 171,000 residents between 139%-400% FPL (income $15,865-$45,960)
- 23% of the uninsured are undocumented immigrants who will not be eligible under the ACA.
- 200,000 individuals receive health care services from Arrowhead Regional Medical Center (ARMC), the Department of Public Health (DPH) and the Department of Behavioral Health (DBH) annually.
  - Services are provided to both insured and uninsured residents, including undocumented immigrants.
- Costs for these 200,000 individuals are currently covered through realignment funds, Mental Health Services Act (MHSA), grants, and other third party revenues such as insurance, Medi-Cal, and Medicare.

** UCLA Center For Health Policy Research, California Health Survey Interviews, Health Policy Fact Sheet, August 2010*

San Bernardino County Efforts

- Health Care Reform Steering Committee established in August 2010.

Arrowhead Regional Medical Center (ARMC)	Transitional Assistance Department (TAD)
Department of Behavioral Health (DBH)	Information, Technology and Support Division (ITSD)
Department of Public Health (DPH)	Program Development Division (PDD)
Department of Aging and Adult Services (DAAS)	Inland Empire Health Plan (IEHP)
Office of Legislative Affairs (OLA)	Molina Health Plan

- Collaborative network and partnerships established.
- Developed and successfully implemented ArrowCare (LIHP) in January 2012.
- Leveraged 50% federal financial participation for 2012 and 2013.
- Built on existing processes and automated systems.
- ArrowCare provides the foundation for a seamless transition in 2014.

County Accomplishments

Established a Bridge To Health Care Reform/ACA

- January 2012 San Bernardino County launched ArrowCare/LIHP for uninsured county residents.
- With ArrowCare over 26,000 additional county residents have access to health care.
- Increased federal revenue for the county.
- Utilized the existing C-IV system to streamline the LIHP transition into Medi-Cal.

Open Lines of Communication Across Departments

- Developed partnerships among departments to service the customer.
- Established a streamlined application process.
- Implemented a "No Wrong Door" approach.
- Launched a co-location of county health services.

THE AFFORDABLE CARE ACT (ACA)

The ACA Objective

The Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act was enacted in 2010 with the objective to:

- Expand access to healthcare coverage
- Make healthcare coverage affordable
- Improve the quality of care consumers receive
- Shift the burden of rising healthcare costs away from the consumer
- Promote preventative care and wellness
- Increase transparency in the healthcare system

Federal Health Care Reform Timeline: When the Changes Happen

MAR 2010
- Seniors who exceed Medicare drug coverage limit receive $250 rebate
- Tax credits for certain small employers begin

JULY 2010
- Uninsured people with health problems eligible for state insurance program

SEPT 2010
- Insurers required to cover sick children
- Lifetime limits on insurer payouts prohibited
- Children allowed to remain on parents' policy until age 26

JAN 2011
- Medicare beneficiaries pay less for preventive care services
- Voluntary payroll deduction for long term care coverage starts

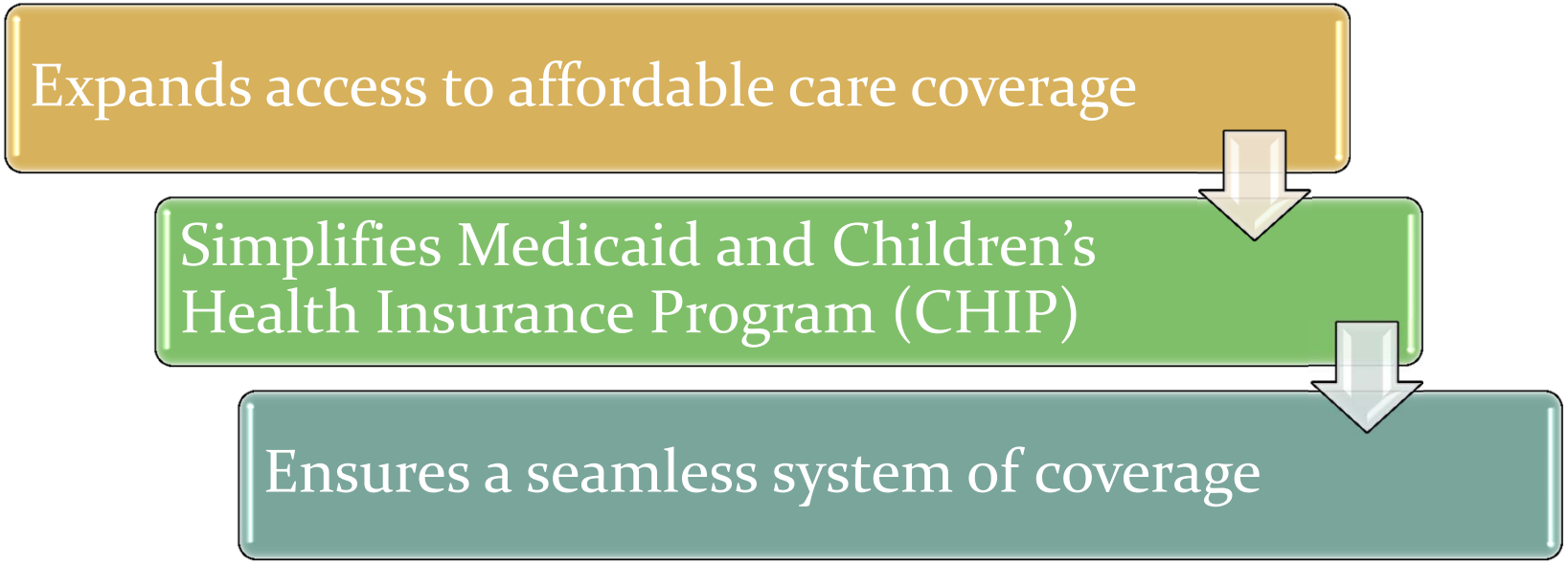
- Supreme Court ruling upheld the ACA and made the Expansion optional for States.

JAN 2013
- Medicare taxes rise on incomes above $200,000 per year

JAN 2014
- Medi-Cal eligibility expanded
- Insurers barred from denying coverage
- Individual requirement to obtain coverage begins
- Insurance exchange opens for business

Individual Mandate

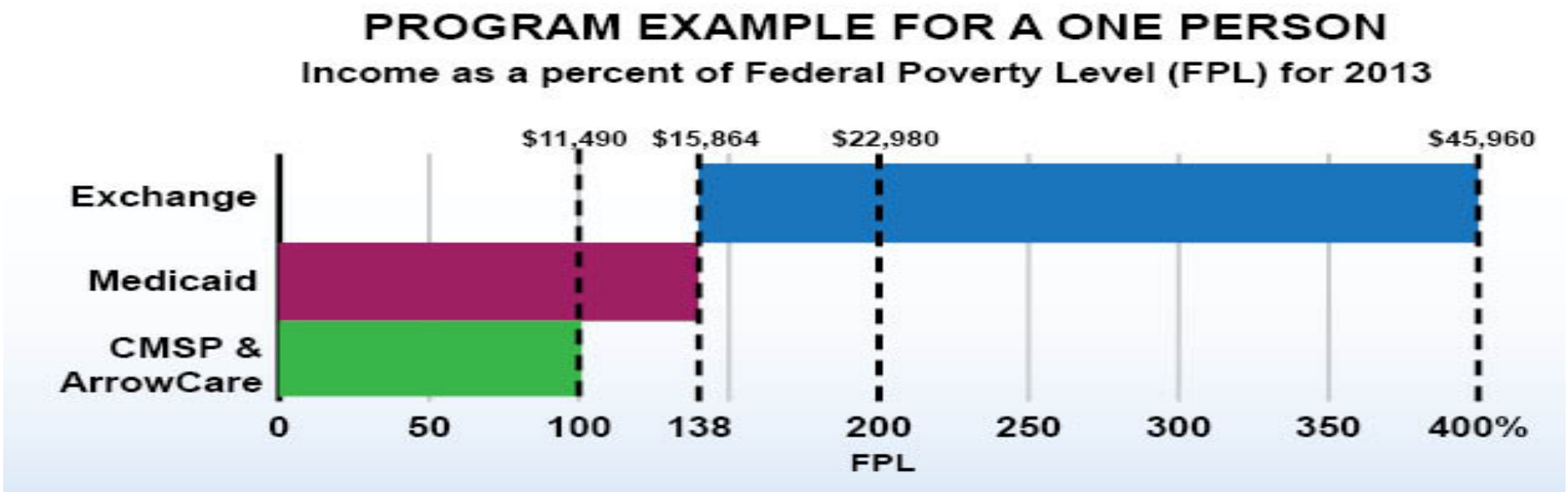
The Individual Mandate requires all Americans to obtain healthcare coverage beginning 2014 or face tax penalties.

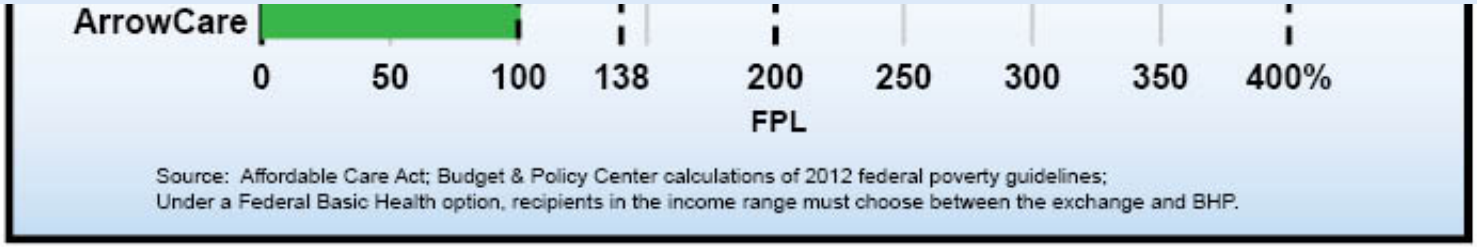


Individuals Not Subject to Tax Penalty

- Individuals with a coverage gap less than three months
- Incarcerated individuals
- Undocumented immigrants
- Religion opposed to acceptance of benefits from a health insurance policy
- Native Americans
- Individuals with income below the threshold required to file a tax return ($9,350 individuals, $18,700 family of four)
- Individuals who pay more than 8% of income for health insurance after employer contributions

System of Coverage





Source: Affordable Care Act; Budget & Policy Center calculations of 2012 federal poverty guidelines;
Under a Federal Basic Health option, recipients in the income range must choose between the exchange and BHP.

California ACA Implementation

Supreme Court decision made the Medi-Cal (Medicaid) Expansion optional for States. California is in the midst of implementing the ACA but has many policy choices pending regarding:

- New eligibility and enrollment for the Health Benefit Exchange (Insurance Marketplace)
- Medi-Cal Expansion

California's Health Benefit Exchange is the primary individual health insurance marketplace for Californians starting in 2014.

Consumers will have new online tools available to compare affordable coverage.

Low-income individuals and families will be able to qualify for Medi-Cal or Premium Subsidies.

Premium Subsidies (Exchange)

- Individuals and families must have an annual household taxable income between 138% and 400% of the Federal Poverty Level (FPL).

	DIFFERENT INCOME LEVELS FOR A CALIFORNIA FAMILY OF FOUR				
	Percent of FPL	Annual Income	Unsubsidized Annual Premium	Annual Tax Credit	Annual Premium after Credit (Annual Out of Pocket)
Medi-Cal Eligible	138%	$31,495	N/A	N/A	N/A
	150%	$35,137	$14,245	$12,840	$1,405
	200%	$47,362	$14,245	$11,294	$2,952
	300%	$71,043	$14,245	$7,569	$6,676
	400%	$94,724	$14,245	$5,344	$8,901

Premium Subsidy Access

- "No wrong door" means county residents may access health insurance through Covered California or the Transitional Assistance Department (TAD).
- Applications may be made online, by telephone, by mail, or in person.
- TAD will process applications and if not eligible to Medi-Cal, will electronically forward to Covered California for health plan enrollment.

Medi-Cal Expansion

- California proposes to expand Medi-Cal to adults age 19-64 with incomes up to 138% of the FPL who are citizens or legal permanent residents.
- Federal reimbursement rates increase from 50% to 100% for the first three years. (The federal reimbursement rate will be reduced to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and onwards)
- The Governor's budget presents two options for Medi-Cal expansion:
  - County Option - Builds on our existing county operated Low Income Health Program (LIHP - ArrowCare) which must offer a minimum core set of benefits.
  - State Option - Standard statewide benefit through existing state-run Medi-Cal in exchange for another realigned program.

County Option

- Expansion is built on existing Low Income Health Programs (LIHPs).
- Counties will need to:
  - Retain current responsibilities for indigent care.
  - Meet the minimum package of health benefits consistent with Covered California.
  - Be responsible for developing provider networks, setting rates and processing claims.
- Issues:
  - 5 counties do not currently have LIHPs.
  - There will be 58 different versions of Medi-Cal expansion and the federal government will likely not approve.
  - Counties will have to expand or build the entire infrastructure in less than 9 months.

State Option

- Expansion is built on the existing state Medi-Cal program and managed care delivery system.
- Offers a standardized state-wide benefit package.
- Redirects existing 1991 Health Realignment funds to pay for new human services program responsibility, specifically Child Care.
- Issues:
  - Administration assumes county savings because more residents will be eligible for Medi-Cal. However there will still be a number of indigents who will need to be served, as well as Public Health mandates that still need to be funded.
  - Child Care is a problematic program to realign; collective bargaining, bifurcated administration, little local flexibility.

Health and Mental Health Realignment

Current Realignment Funds

HEALTH REALIGNMENT

Department	Amount	Purpose/Utilization
ARMC	$38,325,000	Medical Care and Physician Services for indigent and uninsured patients
DPH	$14,164,292	• Disease reporting, monitoring, surveillance and treatment • Immunizations and vaccinations *(especially to the uninsured)* • Preparedness and response *(against bio-terrorist attacks)* • Clinical services to the uninsured

Current Realignment Funds,

continued

MENTAL HEALTH REALIGNMENT

Department	Amount	Purpose/Utilization
DBH	$53,377,199	Mental Health Programs funded under 1991 Realignment: • Community-based mental health programs • State hospital services for county patients • Institutions for Mental Disease • Indigent care
	$35,300,072	Behavioral Health Programs funded under 2011 Realignment: • Drug Medi-Cal • Drug Courts • Perinatal Drug Services • Early and Periodic Screening, Diagnosis and Treatment (EPSDT) • Managed Care (Fee-for- Service Network)

Impact to County Departments

Counties have a number of roles in the health care system and provision of services through Health Care Reform. The impacts of the ACA and state legislation on San Bernardino County vary by department.

Arrowhead Regional Medical Center (ARMC)

The ACA and Covered California changes hold a significant impact to ARMC business process and the services it provides to the community. Impacts include, but are not limited to:

- ARMC competitive position in the Inland Empire
- ARMC managed care and insurance contracting strategy
- Contractual relationships with ARMC medical staff
- Relationships between other hospitals in the county
- ARMC financial reimbursement streams

Ultimately, over time the ACA will impact the Mission/Vision of the Hospital as currently stated.

ARROWHEAD
REGIONAL MEDICAL CENTER

ARMC - Opportunities

- Serve the health/medical needs of the newly expanded county Medi-Cal and insured populations.
- Introduce ARMC to a new patient population.
- Financially sustain its operations and long term growth and expansion.

ARMC – Opportunities,
continued

- Sharpen and further develop ARMC's major service lines such as Obstetrics (OB), Stroke, Neuro Services, Surgery, and Neonatal Intensive Care Unit (NICU).
- Redefine the Mission/Vision and role in the County community.
- Maximize ARMC's financial position.

ARMC - Risks

- Increase in non-covered patients
  - Undocumented immigrants and residual uninsured
- Competitive success
- Adequate Physician Staffing
  - Lack of primary care physicians and general workforce
- Complexity of regulations

ARMC – Risks, *continued*

- Long term volume of uninsured and undocumented immigrant utilization.
- Contracting with providers and managed care plans.
- Decrease in safety net hospital funding:
  - Disproportionate Share Hospital
  - Safety Net Care Pool
  - Realignment
- Continuity of ARMC medical center programs.
- Maintain the **Big 3** at ARMC:
  - Trauma Care
  - Burn Care
  - Physician Training

ARMC - Financial Impacts

- Future reimbursement for public hospitals
- Physician payments
- The ACA will have a significant "change effect" on ARMC financial profile:
  - Increase in Medi-Cal volume
  - Decrease in uninsured volume
  - Funding streams for indigent care such as Safety Net Care Pool, Disproportionate Share, and Realignment.

Transitional Assistance Department

The Medi-Cal expansion and health insurance enrollments will considerably impact eligibility operations for the Transitional Assistance Department (TAD).

TAD - Opportunities

- Established system to determine eligibility
  - Current C-IV Eligibility System will interface with new State Eligibility System (CalHEERS).
- Experienced workforce
- Customer Service Center (CSC)
- Providing access to additional populations for other benefits such as CalFresh

TAD - Risks

- Extended CSC hours of operation required by the state:
  - Open Enrollment - Monday-Saturday: 8 am - 8 pm
  - Non-open enrollment - Monday-Friday: 8 am - 6 pm, Saturday: 8 am - 5 pm
- Service Level Agreements/Performance Standards
- Staffing Capacity/Adequacy
- Lack of state direction/policy
- Expanded capacity needs such as lobby and office space

TAD - Financial Impacts

- Unknown State allocations for newly eligible population and processing in-person ACA applications.
- Funding availability for additional staff.
- Capacity cost to house additional staff and serve increased customer base.
- Increased cost for implementation:
  - Training
  - Technology infrastructure
  - Increased business hours

Department of Behavioral Health

The ACA explicitly includes mental health and substance use disorder benefits, as one of 10 categories of service that must be covered as essential health benefits.

DBH - Opportunities

- Improve access to mental health and substance use disorder treatment services through more equitable coverage.
- Provide access to preventative, rehabilitative and recovery-oriented mental health services.
- Reduce cost for inpatient and emergency room care to better meet the need of individuals with mental illness in the least restrictive environment.

DBH - Risks

- Residual uninsured population responsibility.
- Shortage of behavioral health professionals to meet the need for services.
- Potential changes to the system of care for specialty mental health services.

DBH - Financial Impacts

- Varying 1991 and 2011 Realignment rules will impact current funding.
- Implications for the Mental Health Services Act (MHSA).
- Uncertainty exists, depends on many factors, including:
  - Size of the newly Medi-Cal eligible population,
  - Extent and pace to which this newly eligible population will enroll in the program, and
  - Average per-person costs.

Department of Public Health

Core to all public health is the emphasis on prevention to address health issues. The ACA:

- Provides for renewed emphasis on the importance of prevention by providing for free preventive services and renewed investment in proven prevention programs.
- Recognizes the importance of community health centers, and provides an avenue for the department to increase its efforts towards access to care.

DPH - Opportunities

- Federal funding to support the increased construction of community clinics and expansion of services provided at community clinics
- Improved prevention activities, including provision of free preventive care and increased funding for proven prevention programs through the Prevention and Public Health Trust
- Improved systems for understanding and fighting health disparities

DPH - Risks

- Reduced/eliminated level of federal funding for traditional categorical activities.
  - Including Ryan White for HIV care and treatment.

- Increased need for prevention programs and primary care providers to address access issues for those newly insured, as well as those who will remain uninsurable.

DPH - Financial Impacts

- Increased costs to provide free preventive services.
- Loss of traditional categorical Federal funding.
- Potential loss of 1991 Health Realignment to fund mandated public health activities.

Department of Aging and Adult Services

The Coordinated Care Initiative (CCI) provides integrated medical, behavioral and long-term support services to individuals who are dually eligible to Medi-Cal/Medicare.

- Expected to begin no earlier than October 2013
- CCI requires mandatory enrollment of dual eligibles in Managed Care (i.e. IEHP and Molina) and
- In-Home Supportive Services (IHSS) and Multipurpose Senior Service Program (MSSP) to become a 'benefit' of managed care.

DAAS – Opportunities

- Improved health outcomes and a more efficient health care system at lower costs.
- IHSS Staff will work with Managed Care in Care Coordination Teams.

DAAS - Risks

- Unknown funding for new program responsibilities under the ACA.
- The number of IHSS recipients to receive Coordinated Care services and the eligibility criteria are yet to be determined.

DAAS - Financial Impacts

- Counties' IHSS costs have been pegged at the Fiscal Year 2011-12 level under a Maintenance of Effort (MOE) agreement.
  - The yearly increase in counties' IHSS costs (due to inflation factor) was pegged at 3.5% starting July 1, 2014.
- Costs of additional IHSS tasks under CCI must be negotiated locally with Managed Care.
  - Additional CCI workload may increase IHSS staffing and administrative costs.

California Legislation

Governor's 2011-12 Budget Proposal and the Affordable Care Act

- The cornerstone of the Governor's 2011-12 proposed budget included a "vast and historic" realignment of services from the State to counties.

- Phase 1 proposed the realignment of public safety responsibilities (AB 109) and federal entitlement programs to counties.
- Phase 2 focused on the implementation of the Affordable Care Act.
  - With most individuals served by county indigent programs becoming eligible for Medi-Cal in 2014, the Administration assumes there will be a natural shift of costs from counties to the State.

Board Adopted Policies on the ACA

- Maintain and/or expand the County's long-term funding, such as 1991 Realignment Health funds.
- Provide partnership between stakeholders to achieve desired outcomes.
- Promote a seamless transition to federal health care reform.
- Ensure adequate and guaranteed funding for the remaining public health programs that will remain under local control.

Governor's 2013-14 Budget Proposal Includes Two Options to Expand Medi-Cal

- State Based Option and County Based Option.
- Financial risk to counties exists under both options due to the realignment of proposed social service programs under the state option and share of costs under the county option.
- Uncertainty remains about critical areas including the pace of enrollment, number of individuals that will remain uninsured, access to care, network adequacy and maintaining the counties' safety net.
- Under both proposals a potential loss of 1991 realignment dollars is a concern for counties.

Extraordinary Legislative Session on Health Care

- Governor's proposal aligns Health Care Reform bills through the Extraordinary Legislative Session.
- ABx1 /Perez and SBx1 Hernandez streamline the Medi-Cal eligibility and enrollment and include a statewide Medi-Cal expansion to childless adults under 138% FPL.

The County and Statewide Association Involvement

- The County has been an active participant in shaping polices that statewide associations are using to negotiate with the Administration.
- Statewide associations have been advocating the need to retain county funding for residual responsibilities for indigent and public health services.

Budget Discussions Are Underway on the Implementation of the Affordable Care Act

- Members of the Legislature and the Administration disagree on several key issues, including:
  - The idea that the financing issue, or redirection of county funds, must be in place prior to deciding on a Medi-Cal Expansion model;
  - The Administration's assertion that counties will achieve "savings" as a result of the Affordable Care Act; and
  - The Administration's proposal to realign child care and other social service programs as part of the Medi-Cal expansion.

Unanswered Questions and Remaining Concerns

- Residual responsibilities for health services. All counties will have remaining responsibilities for public health and indigent adults. It is crucial counties retain sufficient realignment funds to deliver services.
- Timing. The county option is unlikely to ensure coverage for the Medi-Cal expansion on January 1, 2014. Significant issues at the local level present challenges to the timely implementation of the ACA.
- Program realignment. The realignment of additional programs to counties is risky. If counties are to take on new risks associated with new programs, counties need constitutional protections . Additionally, counties need assurances that revenues will grow with program mandates and costs.
- We expect the May Revision will provide additional information on the implementation of the Affordable Care Act.

Recommendations

Recommendations

Support:

- A State Based Option of the Medi-Cal Expansion.
- Retention of sufficient realignment funds to deliver public health and remaining indigent services.
- County use of existing realignment funds to leverage federal funds.
- The concept that County savings should only be recognized in arrears once actual savings can be quantified.
- The concept that any savings going back to the state should be a financial transaction only without any programs being realigned to the county.

Additional ACA Resources

Covered California
www.coveredca.com

Health Care Reform
www.healthcare.gov

What is the Insurance Market Place? Video
http://youtu.be/2Rrq8GzWxs8